

Facility Name & ID Number MAPLE RIDGE CARE CENTRE

0042366 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>95</u>	Skilled (SNF)	<u>95</u>	<u>34,675</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>25</u>	Intermediate (ICF)	<u>25</u>	<u>9,125</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,858</u>	<u>617</u>	<u>6,944</u>	<u>11,419</u>	8
9	SNF/PED					9
10	ICF	<u>23,885</u>	<u>3,683</u>	<u>564</u>	<u>28,132</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,743	4,300	7,508	39,551	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.30%

D. How many bed-hold days during this year were paid by Public Aid? 41 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 11/01/96

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 11/01/96 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 32 and days of care provided 4,005

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **MAPLE RIDGE CARE CENTRE** # **0042366** Report Period Beginning: **01/01/2003** Ending: **12/31/2003**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	152,163	18,087	11,197	181,447		181,447	(2,119)	179,328			1
2	Food Purchase		146,813		146,813		146,813	(870)	145,943			2
3	Housekeeping	144,597	16,201		160,798		160,798	(3,214)	157,584			3
4	Laundry	19,482	12,124	194	31,800		31,800	(214)	31,586			4
5	Heat and Other Utilities			121,728	121,728		121,728		121,728			5
6	Maintenance	60,471	24,682	32,437	117,590		117,590	(1,501)	116,089			6
7	Other (specify):*			10,799	10,799		10,799		10,799			7
8	TOTAL General Services	376,713	217,907	176,355	770,975		770,975	(7,918)	763,057			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,249,291	69,548	16,060	1,334,899		1,334,899	(1,545)	1,333,354			10
10a	Therapy			2,485	2,485		2,485		2,485			10a
11	Activities	90,625	5,767	2,812	99,204		99,204	(480)	98,724			11
12	Social Services			2,812	2,812		2,812		2,812			12
13	Nurse Aide Training			84	84		84		84			13
14	Program Transportation			35	35		35		35			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,339,916	75,315	42,288	1,457,519		1,457,519	(2,025)	1,455,494			16
	C. General Administration											
17	Administrative	55,804		390,396	446,200		446,200	(377,848)	68,352			17
18	Directors Fees											18
19	Professional Services			148,014	148,014		148,014	7,923	155,937			19
20	Dues, Fees, Subscriptions & Promotions			72,658	72,658		72,658	(58,192)	14,466			20
21	Clerical & General Office Expenses	90,412	20,567	66,026	177,005		177,005	81,656	258,661			21
22	Employee Benefits & Payroll Taxes			315,154	315,154		315,154		315,154			22
23	Inservice Training & Education			8,163	8,163		8,163		8,163			23
24	Travel and Seminar			235	235		235	7,751	7,986			24
25	Other Admin. Staff Transportation			6,558	6,558		6,558		6,558			25
26	Insurance-Prop.Liab.Malpractice			99,537	99,537		99,537	33,248	132,785			26
27	Other (specify):*			40,532	40,532		40,532	(40,532)				27
28	TOTAL General Administration	146,216	20,567	1,147,273	1,314,056		1,314,056	(345,994)	968,062			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,862,845	313,789	1,365,916	3,542,550		3,542,550	(355,937)	3,186,613			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT XVIII B 35-2	10,438	
	REPAIRS & MAINTENANCE	759	
		0	11,197
3	HOUSEKEEPING		
		0	
		0	0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE	194	
		0	194
5	HEAT & OTHER UTILITIES		
	GAS HEAT	0	
	ELECTRICITY	85,573	
	WATER	33,900	
	CABLE TV - LOBBY	2,255	
		0	121,728
6	MAINTENANCE		
	GROUNDS MAINTENANCE	3,362	
	PAINTING & DECORATING	7,519	
	BUILDING REPAIRS	0	
	MAINTENANCE TRAVEL	0	
	EQUIPMENT MAINTENANCE & REPAIR	7,455	
	ELEVATOR MAINTENANCE & REPAIR	0	
	OUTSIDE LABOR	4,944	
	EXTERMINATING SERVICE	4,839	
	FIRE SERVICE	4,318	
		0	
		0	
		0	32,437
7	OTHER		
	SCAVENGER	10,171	
	SECURITY SERVICE	628	10,799
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES XVIII B 36-2	18,000	18,000

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING XVIII C 53-2		
	LABORATORY & XRAY EXPENSE	0	
	PURCHASED SERVICES	0	
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0	
	PHARMACY CONSULTANT XVIII B 39-2	1,200	
	UTILIZATION REVIEW FEES XVIII B __-2	0	
	PHYSICIANS XVIII B __-2	0	
	PSYCHIATRIC XVIII B __-2	0	
	RN CONSULTANT XVIII B 38-2	14,860	
		0	
		0	16,060
10a	THERAPY		
	PHYSICAL THERAPY SERVICES	2,014	
	SPEECH THERAPY SERVICES	0	
	OCCUPATIONAL THERAPY SERVICES	471	
	REHABILITATION CONSULTANT XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0	2,485
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS	0	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,812	
		0	2,812
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES	0	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0	
	SOCIAL WORKER XVIII B 45-2	2,812	
		0	2,812
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS XIII	84	84

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	35	35
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 390,396	390,396
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 26,975	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 121,039	
		0	148,014
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 20,614	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 24,410	
	EMPLOYEE WANT ADS	XIX F 410	
	CONTRIBUTIONS	VI 20 XIX F 300	
	DUES & SUBSCRIPTIONS	XIX F 11,485	
	LICENSES & PERMITS	XIX F 638	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 13,014	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 828	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 959	72,658
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0	
	EQUIPMENT REPAIR & MAINTENANCE	3,849	
	OUTSIDE CLERICAL SERVICES	1,400	
	PENALTIES / OVERDRAFT CHARGES	VI 18 11,724	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	675	
	TELEPHONE	46,287	
	MESSENGER SERVICE	2,091	
		0	66,026

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 140,548	
	UNEMPLOYMENT COMPENSATION	XIX D 13,566	
	WORKERS COMPENSATION INSURANCE	XIX D 44,361	
	HOSPITALIZATION INSURANCE	XIX D 100,369	
	EMPLOYEE BENEFITS - OTHER	XIX D 10,432	
	EMPLOYEE PHYSICAL EXAMS	XIX D 3,102	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 2,776	
	CHICAGO HEAD TAX	XIX D 0	315,154
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	8,163	8,163
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 235	
		0	
		0	235
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	6,558	6,558
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	99,537	99,537
27	OTHER		
	BAD DEBTS	VI 24 40,532	
		0	40,532

GRAND TOTAL COLUMN 3 OTHER

1,365,916

MAPLE RIDGE CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2003

TOTAL FOOD PURCHASE	146,813	PATIENT MEALS	118653
LESS SALES TAX	(870)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	145,943	TOTAL MEALS/YEAR	118653
TOTAL PATIENT CENSUS	39,551	NET FOOD	145943
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	118653

TOTAL PATIENT MEALS	118653	COST PER MEAL	1.23
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			54,056	54,056		54,056	140,032	194,088			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			181,820	181,820		181,820	226,350	408,170			32
33	Real Estate Taxes			37,663	37,663		37,663		37,663			33
34	Rent-Facility & Grounds			540,000	540,000		540,000	(527,700)	12,300			34
35	Rent-Equipment & Vehicles			19,732	19,732		19,732	5,185	24,917			35
36	Other (specify):* STORAGE			1,732	1,732		1,732		1,732			36
37	TOTAL Ownership			835,003	835,003		835,003	(156,133)	678,870			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		139,636	402,171	541,807		541,807		541,807			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		139,636	467,871	607,507		607,507		607,507			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,862,845	453,425	2,668,790	4,985,060		4,985,060	(512,070)	4,472,990			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(29,485)	30		9
10	Interest and Other Investment Income	(68,126)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(870)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(11,724)	21		18
19	Entertainment	(20,614)	20		19
20	Contributions	(1,128)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(808)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,532)	27		24
25	Fund Raising, Advertising and Promotional	(24,410)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(13,014)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(18,156)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (228,867)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(283,203)	PG 6&6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (283,203)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (512,070)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0042366

Report Period Beginning:01/01/2003

Ending:12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (884)	6	1
2	VACATION ACCRUAL	(2,119)	1	2
3	VACATION ACCRUAL	(3,214)	3	3
4	VACATION ACCRUAL	(214)	4	4
5	VACATION ACCRUAL	(617)	6	5
6	VACATION ACCRUAL	(9,154)	10	6
7	VACATION ACCRUAL	(480)	11	7
8	VACATION ACCRUAL	(1,474)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(18,156)		49

Summary A

12/31/2003

[illegible]

Summary B

12/31/2003

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		FIRST HEALTH CARE ASSOCIATES, LTD (DIVISION OF FHC ENTERPRISES, INC.)	MORTON GROVE, IL	MANAGEMENT/CONSULTANT
				MAPLE RIDGE LLC	MORTON GROVE, IL	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	\$	FHC ENTERPRISES, INC.		\$ 7,609	\$ 7,609	1
2	V	17	ADMINISTRATIVE	390,396	MR. BELLOWS OWNS 95% OF THIS FACILITY		12,548	(377,848)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		4,546	4,546	3
4	V	20	DUES & SUBSCRIPTIONS				974	974	4
5	V	21	CLERICAL				94,854	94,854	5
6	V	24	TRAVEL				7,751	7,751	6
7	V	26	INSURANCE				3,876	3,876	7
8	V	30	DEPRECIATION				2,453	2,453	8
9	V	34	RENT				12,300	12,300	9
10	V	35	RENT- EQUIPMENT & VEH.				5,185	5,185	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 390,396			\$ 152,096	\$ * (238,300)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$ 540,000	MAPLE RIDGE LLC		\$	\$ (540,000)	15
16	V	26	INSURANCE - MORTGAGE		" "		29,372	29,372	16
17	V	30	DEPRECIATION - BLDG/IMPROV		" "		99,146	99,146	17
18	V	30	DEPRECIATION - EQPT		" "		67,918	67,918	18
19	V	32	AMORTIZATION - MTG COST		" "		3,138	3,138	19
20	V	32	INTEREST - MORTGAGE		" "		270,031	270,031	20
21	V	32	INTEREST - OTHER		" "		21,307	21,307	21
22	V	19	ACCOUNTING FEES		" "		4,185	4,185	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 540,000			\$ 495,097	\$ * (44,903)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES, INC.								\$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN	95%	SEE ATTACHED	1.9	8.01	SALARY	12,548	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 12,548		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization FHC ENTERPRISES, INC.
Street Address 8140 RIVER DRIVE
City / State / Zip Code MORTON GROVE, IL 60053
Phone Number (847) 583-0100
Fax Number (8470 583-8873

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	493,454	9	\$ 94,929	\$ 94,929	39,551	\$ 7,609	1
2	17	ADMINISTRATIVE	PATIENT DAYS	493,454	9	159,981	159,981	39,551	12,548	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	493,454	9	56,724		39,551	4,546	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	493,454	9	12,155		39,551	974	4
5	21	CLERICAL	PATIENT DAYS	493,454	9	191,338		39,551	15,336	5
6	21	CLERICAL	DIRECT COST	1	1	79,518	79,518	1	79,518	6
7	24	TRAVEL	PATIENT DAYS	493,454	9	96,702		39,551	7,751	7
8	26	INSURANCE	PATIENT DAYS	493,454	9	48,361		39,551	3,876	8
9	30	DPERECIATION	PATIENT DAYS	493,454	9	30,611		39,551	2,453	9
10	34	RENT	PATIENT DAYS	493,454	9	153,459		39,551	12,300	10
11	35	RENT-EQUIPMENT & VEH.	PATIENT DAYS	493,454	9	64,696		39,551	5,185	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 988,474	\$ 334,428		\$ 152,096	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	RELATED PARTY - MAPLE RIDGE LLC.						\$		\$			\$	1
2	GMAC MORTGAGE COST		X	MORTGAGE	\$33,942.44	07/2002		3,715,350	3,675,603	07/2037	6.6600	270,031	2
3	LOAN COST		X	LOAN COST - AMORT 35 YRS				119,751	111,204			3,138	3
4													4
5													5
	Working Capital												
6													6
7	RELATED FACILITIES	X		WORKING CAPITAL	DEMAND	DEMAND		783,000	2,604,665	DEMNAD	VARIES	181,820	7
8	NOTE TO LANDMARK	X		WORKING CAPITAL	DEMAND	DEMAND		450,000	742,239	DEMNAD	VARIES	21,307	8
9	TOTAL Facility Related				\$33,942.44		\$	5,068,101	\$	7,133,711			9
	B. Non-Facility Related*												
10	IRS, IDR, ETC		X	LATE FEES									10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$	5,068,101	\$	7,133,711			15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 29,372 Line # 26

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.				\$	29,916 1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	33,607 2
3. Under or (over) accrual (line 2 minus line 1).				\$	3,691 3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	33,972 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	37,663 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1998	29,229	8	
		1999	29,063	9	
		2000	28,695	10	
		2001	29,586	11	
		2002	33,607	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

MAPLE RIDGE CARE CENTRE

COUNTY

LOGAN

FACILITY IDPH LICENSE NUMBER

0042366

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	08-029-019-00	NURSING HOME	\$ 33,607.18	\$ 33,607.18
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 33,607.18	\$ 33,607.18

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: **34,774**

B. General Construction Type: Exterior **MASONRY** Frame **STEEL/WOOD** Number of Stories **1**

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	170,750	1996	\$ 148,352	1
2					2
3	TOTALS	170,750		\$ 148,352	3

Facility Name & ID Number **MAPLE RIDGE CARE CENTRE**# **0042366**

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1996		\$ 2,496,225	\$ 90,772	27.5	\$ 90,772	\$	\$ 654,314	4
5			1997		15,792	574	27.5	574		3,708	5
6											6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - MAPLERIDGE LLC										9
10	DINING ROOM REMODELING			1997	7,441	271	27.5	271		1,748	10
11	FENCE			1997	4,300	156	27.5	156		1,009	11
12	WALLCOVERING/TILE WORK			1997	11,399	415	27.5	415		2,678	12
13	INSTALLATION OF WALLCOVERING			1997	10,590	385	27.5	385		2,487	13
14	FLOOR TILES/INSTALLATION			1997	1,160	42	27.5	42		272	14
15	OUTDOOR SIGN			1997	10,880	396	27.5	396		2,556	15
16	WALLCOVERING/TILE WORK/INSTALLATION			1998	30,545	1,111	27.5	1,111		6,063	16
17	WALLCOVERING/DRYWALL/WINDOW FRAMES			1999	31,471	1,144	27.5	1,144		5,102	17
18	OUTDOOR SIGN			1999	4,190	152	27.5	152		679	18
19	PAVEMENT			1999	6,230	227	27.5	227		1,010	19
20	REMODELING, OFFICE, ROOF CURB, DOORS			2000	22,801	829	27.5	829		2,867	20
21	WALLCOVERING, PAINTING			2000	3,683	134	27.5	134		463	21
22	PAINT & PREP ALL DOORS, BATHROOMS, KITCHEN, STORE RM			2001	13,835	503	27.5	503		1,237	22
23	EDGE VENEER COUNTER TOPS			2001	1,028	37	27.5	37		92	23
24	REMOVE & INSTALL I05 SYSTEM RUBBER ROOFING			2001	9,880	359	27.5	359		883	24
25	REPLACE DAMAGED SOFFIT & FASCIA ON THE OUTSIDE			2001	2,486	90	27.5	90		222	25
26	TEAR OUT AND REBUILD SECTION OF ASPHALT PRKG LOT			2002	4,477	163	27.5	163		238	26
27	EXTEND 2 WALLS TO ROOF DECK & DRYWALL COVER			2002	4,034	147	27.5	147		214	27
28	NURSING STATION - CALL LIGHT SYSTEM			2002	28,723	1,044	27.5	1,044		1,523	28
29	RUN ELECTRICITY OUT TO THE PAVILLION			2002	1,396	51	27.5	51		75	29
30	RAISE FLOORS IN 4 ROOMS, ALONG OUTSIDE WALL			2003	3,570	27	27.5	27		27	30
31	REPAIR ASPHALT - ENTIRE PARKING LOT			2003	8,545	65	27.5	65		65	31
32	INSTALL ROOFTOP UNIT			2003	6,918	52	27.5	52		52	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,741,599	\$ 99,146		\$ 99,146	\$	\$ 689,584	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)									
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6		
71	Purchased in Prior Years	\$ 256,681	\$ 27,168	\$ 22,056	\$ (5,112)	3-10 YRS	\$ 104,179	71	
72	Current Year Purchases	50,309	26,888	2,515	(24,373)	3-10 YRS	2,515	72	
73	Fully Depreciated Assets	18,540					18,540	73	
74	RELATED PARTIES	679,175	70,371	70,371			509,385	74	
75	TOTALS	\$ 1,004,705	\$ 124,427	\$ 94,942	\$ (29,485)		\$ 634,619	75	

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	3,894,656
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	223,573
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	194,088
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(29,485)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,324,203

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
-

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 16,190 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	99 DODGE DURANGO	\$ 295.13	\$ 3,542	17
18					18
19					19
20					20
21	TOTAL		\$ 295.13	\$ 3,542	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	\$
13.	/2005	\$
14.	/2006	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☒

80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☒

☐

40

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 34	\$	\$ 34
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		\$ 50		50
9	TOTALS	\$	\$ 84	\$	\$ 84
10	SUM OF line 9, col. 1 and 2 (e)	\$	84		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 150,754	\$		\$ 150,754	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			67,191			67,191	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			183,568			183,568	4
5	Physician Care		visits			425			425	5
6	Dental Care		visits			233			233	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				83,532		83,532	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, I.V. THERAPY & Other (specify): RENTAL	39-2					56,104		56,104	13
14	TOTAL			\$		\$ 402,171	\$ 139,636		\$ 541,807	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 28,341	\$ 239,340	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,425)	842,680	842,680	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,322	73,730	6
7	Other Prepaid Expenses	8,348	8,348	7
8	Accounts Receivable (owners or related parties)	411,227	213,401	8
9	Other(specify): <u>ESCROW DEPOSIT</u>		1,322,365	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,315,918	\$ 2,699,864	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	1,090,218	1,201,934	11
12	Long-Term Investments			12
13	Land		585,600	13
14	Buildings, at Historical Cost		3,318,321	14
15	Leasehold Improvements, at Historical Cost		290,489	15
16	Equipment, at Historical Cost	306,990	1,166,165	16
17	Accumulated Depreciation (book methods)	(241,486)	(2,006,978)	17
18	Deferred Charges	2,567	113,771	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CONSTRUCT. IN PROG.</u>		6,056	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,158,289	\$ 4,675,358	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,474,207	\$ 7,375,222	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 119,637	\$ 135,168	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,985	10,985	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	55,510	55,510	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,139	27,235	31
32	Accrued Real Estate Taxes(Sch.IX-B)		33,972	32
33	Accrued Interest Payable	32,383	35,898	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>MANAGEMENT FEES</u>			36
37	<u>DUE TO IDPA</u>	7,319	7,319	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 231,973	\$ 306,087	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,604,665	742,239	39
40	Mortgage Payable		5,928,393	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,604,665	\$ 6,670,632	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,836,638	\$ 6,976,719	46
47	TOTAL EQUITY(page 18, line 24)	\$ (362,431)	\$ 398,503	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,474,207	\$ 7,375,222	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (277,844)	1
2	Restatements (describe):		2
3	2002 DEPRECIATION ADJ.	(3,495)	3
4	ROUNDING ADJ.	1	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (281,338)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(31,093)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(50,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (81,093)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (362,431)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,885,387	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,885,387	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	742	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 742	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	68,126	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 68,126	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,954,255	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	770,975	31
32	Health Care	1,457,519	32
33	General Administration	1,314,056	33
	B. Capital Expense		
34	Ownership	835,003	34
	C. Ancillary Expense		
35	Special Cost Centers	541,807	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37	NET VENDING COSTS	288	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,985,348	40
41	Income before Income Taxes (line 30 minus line 40)**	(31,093)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (31,093)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,239	1,326	\$ 35,918	\$ 27.09	1
2	Assistant Director of Nursing	4,449	4,507	108,325	24.03	2
3	Registered Nurses	1,650	1,672	34,634	20.71	3
4	Licensed Practical Nurses	26,613	29,555	479,185	16.21	4
5	Nurse Aides & Orderlies	59,535	63,108	591,229	9.37	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,090	9,786	90,625	9.26	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	6,243	6,600	65,735	9.96	14
15	Cook Helpers/Assistants	11,759	12,362	86,428	6.99	15
16	Dishwashers					16
17	Maintenance Workers	4,283	4,549	60,471	13.29	17
18	Housekeepers	15,947	17,000	144,597	8.51	18
19	Laundry	2,935	3,157	19,482	6.17	19
20	Administrator	1,961	2,302	55,804	24.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,920	6,144	90,412	14.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	151,624	162,068	\$ 1,862,845 *	\$ 11.49	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	182	\$ 10,438	1-3	35
36	Medical Director	96	18,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	423	14,860	10-3	38
39	Pharmacist Consultant	96	1,200	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	48	2,812	11-3	44
45	Social Service Consultant	48	2,812	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	893	\$ 50,122		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
MICHELLE EYRSE	ADMIN		\$ 55,804	Workers' Compensation Insurance		\$ 44,361	IDPH License Fee		\$		
			0	Unemployment Compensation Insurance		13,566	Advertising: Employee Recruitment		410		
				FICA Taxes		140,548	Health Care Worker Background Check		959		
				Employee Health Insurance		100,369	(Indicate # of checks performed)				
				Employee Meals		0	MARKETING/ADV/PROMO		58,038		
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC		1,128		
				EMPLOYEE BENEFITS - OTHER		10,432	LICENSES & PERMITS		638		
				EMPLOYEE PHYSICAL EXAMS		3,102	DUES & SUBSCRIPTIONS		11,485		
				PENSION/PROFIT SHARING PLANS		2,776	MGMT CO ALLOCATION		974		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 55,804	CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC		(1,128)		
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense		(20,614)		
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising		(24,410)		
Description			Amount				Yellow page advertising		(13,014)		
FIRST HEALTH CARE	MANAGEMENT FEES		\$ 390,396								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 390,396	TOTAL (agree to Schedule V, line 22, col.8)			\$ 315,154				
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
C. Professional Services											
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
			\$			\$	Out-of-State Travel		\$		
							In-State Travel				
							TRAVEL		235		
							RELATED PARTY		7,751		
							Seminar Expense				
									0		
SEE SCHEDULE ATTACHED			148,014				Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3)			\$ 148,014	TOTAL			(agree to Sch. V, line 24, col. 8)				
(If total legal fees exceed \$2500 attach copy of invoices.)							TOTAL				

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATING	06/2000	\$ 1,366	3	\$ 228	\$ 455	\$ 455	\$ 228	\$	\$	\$	\$	\$
2	PAINTING/DECORATING	06/2001	3,199	3		533	1,066	1,066	534				
3	PAINTING/DECORATING	06/2002	12,265	3			2,044	4,088	4,088	2,045			
4	PAINTING/DECORATING	06/2003	7,519	3				1,253	2,506	2,506	1,254		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 24,349		\$ 228	\$ 988	\$ 3,565	\$ 6,635	\$ 7,128	\$ 4,551	\$ 1,254	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILL. HEALTHCARE ASSOC. - \$10134
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 607 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees